MEDICAL STAFF RULES AND REGULATIONS
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EFFECTIVE 1/1/05 – 12/31/05

MEDICAL STAFF RULES AND REGULATIONS

Section 1: Treatment of Patients

1.1 The Medical Center shall provide care to those patients for whom appropriate resources are available.

1.2 A patient will be admitted to the inpatient service only by a provider who has been granted privileges to admit patients.

1.3 The provider will certify that the patient's admission is medically indicated.

1.4 Transfer to and from the Emergency Room:

A medical screening exam shall be performed by a qualified medical person to any individual who comes to the Medical Center and seeks an examination or medical treatment to determine if the individual has an Emergency Medical Condition, whether or not eligible for insurance and regardless of ability to pay. If it is determined that the individual has an Emergency Medical Condition, the individual will be provided with such further medical examination and treatment as required to stabilize the Emergency Medical Condition, within the capability of the Medical Center, or arrangements for transfer of the individual to another medical facility in accordance with the procedures set forth in the approved policy. Refer to Standard Practice Policy for complete description of policy and procedure requirements.

Section 2: Physician Role

2.1 Assignment to the Teaching Program

Patients admitted by members of the Teaching staff will be teaching patients and will have House Staff assigned to their care. Patients admitted by other staff will have a House Staff member assigned to their care, only if such assignment has been approved in writing by the House Staff's own program director and the involved Department Chairman.

2.2 Care of Non Teaching Patients

For non teaching patients, the attending will be responsible for the history and physical exam, for directing the course of treatment, for documentation in the medical record and for communicating with the patient and family. In the event of a medical emergency, members of the House Staff will oversee the initial treatment required to prevent loss of life or significant injury to the patient until the assigned physician is available.

2.3 Coverage

Physicians are required to make specific arrangements for a physician of similar qualifications to care for their patients during an absence from the Medical Center.

Physicians providing patient care coverage on an "on-call" basis, must be able to arrive at the Medical Center within a reasonable time, generally no more than 30 minutes.

2.4 House Staff Responsibilities

House Staff function under the supervision of the attending physician who retains the ultimate responsibility for the patient's care. Supervision may include but is not limited

to case presentations, rounds, direct supervision and consultation regarding specific aspects of patient management.

The active involvement of the attending physician in the care of a particular patient will be clearly documented throughout the medical record.

House Staff responsibilities include:

2.4-1 taking the medical history and performing physical examinations
2.4-2 directing medical care during the course of treatment
2.4-3 writing orders for the patient's care
2.4-4 completing records of the care provided promptly and accurately
2.4-5 communicating appropriately with referring providers, the patient, and the patient's family

2.5 Medical Students

Medical Students function under the supervision of the attending physician who retains the ultimate responsibility for the patient's care. A medical student can write a note, take review of systems, take past, family and social history and act as a scribe to the licensed physician and document the medical decision with the diagnosis and plan. The attending physician must verify the History and Physical Information (HPI).

Section 3: Medical Center Death

3.1 The patient will be pronounced dead by the attending physician or other licensed practitioners within a reasonable time. A note describing the cause and circumstance of the patient's death will be made by the treating physician in the medical record.

3.2 Request for Autopsy

The attending physician or designee is expected to request an autopsy in the following situations:

I) Deaths in which autopsy may help to explain unknown and unanticipated medical complications to the attending physician;

II) All deaths in which the cause of death is not known with certainty on clinical grounds;

III) Cases in which autopsy may help to allay the concerns of the family or public regarding the death and to provide reassurance to them regarding the same;

IV) Unexpected or unexplained deaths occurring during or following any dental, medical, or surgical diagnostic procedure or therapy,

V) Natural deaths that are subject to, but waived by, a forensic medical jurisdiction such as:
   A) persons dead on arrival to hospitals
   B) deaths occurring in hospitals within 24 hours of admission, and
   C) deaths in which the patient sustained or apparently sustained an injury while hospitalized;

VI) Deaths resulting from high-risk infectious and contagious diseases;

VII) All obstetric deaths;

VIII) All neonatal and pediatric deaths.

3.3 Autopsies will be performed only with the written consent of a legally authorized person on the approved form. In cases within the jurisdiction of the Coroner, his or her authorization will be obtained first. The Department of Laboratory Medicine will notify concerned physicians and interested personnel of the date and time of an autopsy. Provisional anatomic diagnosis will be recorded on the medical record within 36 hours of the autopsy.

A report of the gross findings from the autopsy is to be in the chart within 15 days of the autopsy. The report of microscopic findings is to be completed within 60 days.

Section 4: The Medical Record

4.1 Content

A unique medical record will be maintained for each patient treated at the Medical Center and the satellite facilities, which it operates. The record will include reports of:

4.1-1 examinations performed
4.1-2 diagnostic tests
4.1-3 assessments conducted
4.1-4 procedures performed
4.1-5 treatment provided
4.1-6 consultations
4.1-7 the patient's response to treatment
4.1-8 the patient's informed consent, as applicable
4.1-9 patient/family education provided as applicable
4.1-10 demographic information
4.1-11 conditions of admission/treatment
4.1-12 Discharge instructions

All individuals providing direct patient care will document care as appropriate. Each is expected to be aware of relevant information entered by other providers and other disciplines. Outside records, including correspondence, may be a part of the medical record.

4.2 History and Physical Exam

I) Inpatient

A complete history and physical examination shall be recorded within 24 hours of admission to the inpatient service. It will include a social, family and medical history as well as an assessment of all systems of the body pertinent to the age and diagnosis of the patient. A brief admission note shall be on the chart within 12 hours of the admission.

II) Preoperative

A complete history and physical exam is required before any procedure is performed in the operating room and before the performance of those procedures defined as Group I procedures by the Medical Executive Committee regardless of whether the procedure is done on inpatient or outpatient basis. The preprocedure assessment will include any diagnostic tests indicated. If a complete history and physical exam have been completed within thirty days immediately preceding a procedure, it may be

placed in the chart. An interval note is to be entered by the responsible provider.

III) Outpatient Procedures

For minor outpatient procedures, which do not require conscious sedation, the history and physical exam will be pertinent to the reason for treatment and the planned procedure.

IV) Deferring History and Physical Exam

The history and physical examination will be recorded before an operation, or any potentially hazardous diagnostic procedure unless the physician documents that the need is emergent and failure to perform the procedure within 24 hours could result in serious injury to the patient or death. For urgent procedures which must be done within 72 hours to prevent injury, a complete history and physical exam are required.

4.3 Progress Notes

Progress notes will provide a pertinent chronological report of the patient's condition, results of treatment and the hospital course. They are to document the indications for diagnostic tests, procedures, consultations, the need for continued hospitalization and plans for post hospital care. They may be recorded by the House Staff, Allied Health Professionals, or the attending physician. Each of the patient's clinical problems is to be clearly identified and correlated with specific orders and the results of tests and treatment. Progress notes shall be written at least daily.

4.4 Reports of Surgical and Other Major Procedures

A written Operative/Invasive Procedure Report will be placed in the medical record immediately after surgery to provide pertinent information for anyone required to attend to the patient. This interim report will describe the indications for the procedure, a detailed account of the findings, a description of the techniques, the name of the primary physician and any assistants.

A more detailed report will be dictated immediately after surgery. This report will be completed and signed within 14 days of discharge.

A physician with delinquent reports may be restricted from performing surgical and other major procedures by the Medical Director or designee.

4.5 Treatment Plan

A treatment plan is to be developed for each patient and updated as needed. Treatment plans are to include problem statement(s), the goals and objectives of treatment, and the services to be provided.

At a minimum, the responsible provider will update the plan when the patient is transferred from one level of care to another, and/or following a surgical or Group I procedure and/or when there is a significant change in the patient's condition.

4.6 Consultations

Consultants will document on the patient's record that the consultant reviewed the patient's record and examined the patient. The consultant will provide a written opinion and recommendation(s).

Consultations are to be obtained by the responsible provider as indicated. In particular, they are to be obtained where there are prolonged unresolved diagnostic or therapeutic problems, unexpected complications, failure of treatment, or situations outside the responsible provider's scope of practice or clinical expertise. The consultant is to see inpatients within 24 hours of the request. The Chairman of a Department, Director of Service, or Medical Director may also order a consultation for any patient if they determine such consultation is medically indicated.

4.7 Obstetrical Record

The obstetrical record will include a complete prenatal record or documentation as to why a prenatal record is not included.

4.8 Authentication of Chart Entries

I) Signatures

All entries in the medical record are to be dated, timed, legible and authenticated. This may be accomplished by:

A) Signing the entry at the time it is written in the record.

B) Using a computer key to authenticate a chart entry.

C) Using a computer key or written signature to authenticate a transcribed report, a report can not be signed or authenticated until after it has been transcribed.

D) Using a signature stamp if the provider has filed a letter with the Medical Records Department stating that he/she is sole user of the stamp. Signature stamps may not be used to sign or cosign medication orders. If so used, the President of the Medical Staff may withdraw the practitioner's authority to use same.

E) A written signature is defined as the first initial, last name and title.

II) Abbreviations

A) Only symbols and abbreviations approved by the Executive Committee may be used. The list will be updated no less than annually.

III) Standing Orders

A) Standing orders must be approved annually by the Pharmacy and Therapeutics Committee. When used the orders will be placed in the patient's record, dated, and signed by the physician.

4.9 Discharge Summary

A discharge summary is to be completed following discharge. It will include the reason for hospitalization, significant findings, procedures performed, treatment rendered, hospital course, condition of the patient on discharge or transfer, discharge instructions and follow-up plans. It will be authenticated by the responsible provider.

Summaries will be completed for all patients hospitalized longer than 48 hours, those who have had a cesarean section and those who had a significant and unexpected adverse outcome regardless of length of stay.

For patients with a routine stay of 48 hours or less, or patients with non-complicated vaginal births involving patient stays more than 48 hours, a completed face sheet, signed by the responsible physician, may be substituted for a discharge summary. The final diagnosis must be recorded without symbols or abbreviations and signed by the responsible physician.

If the patient is being transferred to another health care facility, a complete summary is to accompany the patient.

4.10 Release of Information

I) The patient's written consent is required for release of medical information to persons not otherwise authorized to receive such information.

II) All records are the property of the Medical Center and may be removed from the Medical Center only in accordance with a court order, subpoena or the permission of the Medical Center Director. The Manager of Medical Records or designee serves as the Custodian of Records. Unauthorized removal of charts from the Medical Center is grounds for suspension of a practitioner for a period to be determined by the Executive Committee.

III) Medical Staff access to medical records for purposes of research must be approved by the Institutional Review Board. The confidentiality of personal information concerning the individual patient is to be protected. At the discretion of the Medical Center Director, former members of the Medical Staff may be permitted access to the medical records of their patients for the periods during which they treated the patients at the Medical Center.

4.11 Completion

I) The patient's medical record is to be completed within 14 days of discharge by the responsible member of the House Staff or by the attending physician.

II) The Medical Records Department will make available to all providers comprehensive lists of outstanding records and the required date of completion. The list will be provided to the Department Chairmen, the Residency Program Directors and the Medical Director.

III) If an attending physician fails to complete medical records on a timely basis, the Medical Director or designee may suspend the physician's admitting, operating, and consultation privileges, and/or enforce other pertinent contractual stipulations.

IV) A member of the House Staff who fails to complete medical records on a timely basis may be removed from a clinical rotation and assigned to the Medical Records Department. Missed clinical time must be made up.

Section 5: General Conduct of Care

5.1 Consents

I) General Consent for Treatment shall be obtained for routine care and procedures with little or no risk. Documentation thereof is to be obtained:
   A) At the time of each admission to the Medical Center as an inpatient.
   B) At the time of each admission to the Emergency Department.
   C) At the time of the initial admission to Ambulatory Care either to a Family Health Center or a Specialty Clinical and annually thereafter.

Separate documentation is required for each type of service.

II) Informed Consent shall be obtained for complex and/or invasive procedures, including non-emergent administration of blood and blood products. The Medical Staff Organization has established criteria to determine whether or nor an informed consent is required for a particular procedure. The provider who will be performing the procedure is responsible for providing the patient with information about the proposed procedure, risks, benefits and alternatives so that the patient can make an informed decision. The provider is responsible for documenting that the informed consent was obtained and for ensuring that the appropriate form is completed to document that the informed consent has been obtained. Refer to Standard Practice Policy for complete description of policy and procedure requirements.

III) Treatment in the Absence of Consent

In the absence of consent, treatment should not be provided except in a medical emergency, where consent is implied by law. Medical emergencies are defined as:

A) Services required to diagnose and treat unforeseeable medical conditions which if untreated will result in serious disability or death or for which immediate treatment is required to alleviate severe pain.

B) Only the emergency medical condition may be treated.

A) In those cases where it is necessary to proceed without consent, the medical record should show clearly:
   i) The reasons why the patient is unable to consent to the proposed course of treatment
   ii) The efforts which have been made to locate a responsible family member.
   iii) Immediate threat to life or limb, the reasons why treatment, in the absence of consent, is medically necessary.
   iv) The involvement of the responsible attending physician in the decision to proceed with treatment.

Refer to Standard Practice Policy for complete description of policy and procedure requirements.

5.2 Orders

I) All orders must be dated, timed and clearly, legibly, and completely written.

II) Verbal orders may be accepted if dictated to registered nurses, physicians' assistants, and pharmacists. Laboratory technologists, radiology technologists, physical therapists, occupational therapists and respiratory therapists may take a verbal order for administration of medication for limited use in their specialty as approved by the Medical Staff and signed by the physician. Dietitians may take a verbal order concerning the patient’s diet to be signed by the physician.

All verbal orders will include the name of the ordering provider and will be signed by the person to whom they were dictated. The responsible practitioner is to countersign verbal orders for seclusion and restraints within 24 hours and medications within 48 hours.

III) Orders are automatically canceled when patients go to the operating room.

IV) To the extent permitted by law, Allied Health Professionals may initiate verbal orders, written orders as transmittal orders from the physician, or orders authorized by the standardized protocol under which the AHP is practicing.

V) Either the attending physician or fellow must counter-sign the DNR order.

VI) The ordering physician may not be able to authenticate his or her verbal order. In such cases, it is acceptable for a covering physician to co-sign the verbal order of the ordering physician when the ordering physician gives a verbal order which is written and transcribed, and then is "off duty" for next day or two or on vacation. The signature indicates that the covering physician assumes responsibility for his/her colleague's order as being complete, accurate and final. It is not acceptable for the covering physician to authenticate verbal orders as a routine, for convenience or to make this a common practice.

5.3 Administration of Medication

I) Drugs and medications administered to patients shall be those listed in the latest edition of the United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or AMA drug evaluation. Drugs for bona fide clinical investigations may be exceptions if used in full accord with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration. Drugs brought to the Medical Center by patients will be kept in the nursing units and dispensed by the nurses if ordered or held in safekeeping for the patient until time of discharge.

II) Automatic Stop Orders

A. Medications will be reviewed and rewritten by the prescriber as follows:

1. Narcotics - Injectable/oral 5 days
2. Hypnotics - Injectable/oral 7 days
3. Anticoagulants - 24 hours
4. Parenteral Nutrition- 24 hours
5. Antineoplastics - 1 day or per protocol
6. All others - 14 days

B. Automatic stop dates may be superseded when the physician prescribes any medication for a specific length of time or duration.

5.4 Patient Rights

It is the physician's responsibility to respect the personal dignity and unique needs of each patient. The physician will affirm the rights of the patient and/or duly authorized representative to make decisions regarding health care including the decision to discontinue treatment to the extent permitted by law. A physician who is unable to continue care as a result of such decisions will make every reasonable effort to help the patient/representative arrange an appropriate transfer.

5.5 Patient Education

The physician is responsible for ensuring that the patient and family receive appropriate education regarding the illness and the treatment.

5.6 Ordering of Diagnostic Tests by Outside Providers

Providers who are not members of the Medical Staff may refer patients to the Medical Center for outpatient diagnostic tests. Provider is to provide specific orders for each such test.

Section 6: General Rules Regarding Emergency Service

6.1 A sufficient number of licensed physicians with clinical privileges in the Department of Emergency Medicine will be on duty at all times. A schedule will be posted showing physician assignments.

6.2 The Medical Staff will provide specialty consultation in the emergency department. The call schedule for each specialty is posted in the emergency department or at the switchboard.

6.3 The duties and responsibilities of all caregivers within the emergency area will be defined. A procedure manual, available for staff use will be approved by the Executive Committee at least every two years.

6.4 A record will be kept for every patient receiving emergency service, which will become a part of the medical record. It will include:

I) Patient-identifying information or the reason for its absence.
II) The time and means of the patient's arrival.
III) Pertinent history, including details of prehospital care.

Section 7: General Rules Regarding Obstetrical Care

Obstetrical care will meet the guidelines for Obstetric-Gynecologic Hospital Services of the American College of Obstetricians and Gynecologists including its policy on surgical sterilization and California law regarding sterilization and hysterectomy.

Section 8: General Rules Regarding Psychiatric Care

Psychosurgery, electroconvulsive therapy, and aversion therapy for modification of behavior of a patient will not be used.

A multidisciplinary treatment plan will be completed for each patient following admission and will be updated as indicated. The attending physician will review and approve each such plan within the time limits specified by the Department of Behavioral Health.

A patient known or suspected to be a potential danger to self or others will be evaluated by a Psychiatrist at the Department of Behavioral Health and will be admitted to the Behavioral Health Unit if appropriate. If a bed is not available in the Behavioral Health Unit, or if the patient needs to be treated on a medical unit, restraints and observation may be provided as described in Section 12.

Section 9: General Rules Regarding Alcohol and/or Drug Rehabilitation Services

The Medical Center does not provide alcohol and/or drug rehabilitation services. Medical Staff members and other providers will provide care for medical problems of patients diagnosed as substance abusers. As indicated, the providers will assist such

patients to identify appropriate resources for treatment of the substance abuse problems.

Section 10: General Rules Regarding Special Care Units

There will be a Medical Director for each special care unit. There will be criteria approved by the Specialty Care Committee, which define appropriate admissions to and discharges from these units. The Medical Director of the unit will be consulted in the event of questions about the appropriate application of these criteria. If unresolved, the Medical Director of the Medical Center will be consulted.

Section 11: General Rules Regarding Surgical Care

11.1 The Anesthesia Provider will maintain a complete anesthesia record providing evidence of the pre-anesthetic evaluation and post-anesthetic follow-up including the presence or absence of anesthesia-related complications. A postoperative visit to inpatients will be made after complete recovery from anesthesia.

Surgeons must be in the operating room and ready to commence operations at the time scheduled and in no case will the operating room be held longer than fifteen (15) minutes after the time scheduled.

The operating surgeons will have an assistant at all major operations so designated by the department.

11.2 All tissues or objects removed during an operation or Group 1 Procedure will be sent to the Medical Center Pathologist except for those objects taken by law enforcement. Exceptions to this rule are the circumcision foreskin on newborns, toenails or fingernails, grossly normal placenta from NSVD and cesarean sections, therapeutic radioactive sources, fat from liposuction, body hair removed to prepare incision sites, incidental debris (as a consequence of surgical exposure), teeth (provided the number including fragments is recorded in the medical record), catheters and other medical foreign bodies and such other specimens as may be approved by the Executive Committee. The Pathologist's report will be part of the patient's medical record.

No flammable anesthetics may be used in the Medical Center.

Section 12: General Rules Regarding Restraint and Seclusion

A restraint may only be used to protect the patient from injuring himself or others, or to improve patient well being and assessment and the use of less restrictive intervention has been determined ineffective. Restraints are applied by order of a licensed physician. Restraints are not specific to any treatment setting but to the situation. The decision to use restraint is not driven by diagnosis but by comprehensive individual patient assessment. Staff are encouraged to intervene early before any emergencies dictate the need for restraint or seclusion by providing support and encouraging patients to calm down and regain control of their behavior. House Supervisor and Unit Manager or designee will be notified immediately if a behavioral restraint or leather restraint is ordered in an acute care setting 24/7. Refer to Standard Practice Policy for complete description of policy and procedure requirements.

Section 13: General Rules Regarding Complementary Medicine

As a component of a patient’s care, complementary treatment modalities may be made available to patients. Such treatment will be provided by a physician member of the Medical Staff who has been granted clinical privileges to do so. The Rules and Regulations of the Department(s) involved will describe the qualifications required to obtain privileges in each such modality and the proctoring/monitoring system. The Department’s privilege list will describe those modalities for which its members may request privileges.

Section 14: General Rules Regarding Telemedicine

As a component of patient care, Telemedicine treatment modalities may be made available to patients. Telemedicine involves the use of electronic communication or other communication technologies to provide or support clinical care at a distance. Practitioners who render a diagnosis or otherwise provide clinical treatment to a patient by Telemedicine are subject to the Medical Staff credentialing and privileging processes.

Telemedicine Services may be provided in the following clinical Departments:

a. Department of Anesthesia
b. Department of Emergency Medicine
c. Department of Family Medicine
d. Department of Laboratory Medicine
e. Department of Medical Imaging
f. Department of Medicine
g. Department of Orthopedics
h. Department of Pediatrics
i. Department of Surgery
j. Department of Women's Health Services

In order to qualify for privileges to render Telemedicine Services, the practitioner must meet all the requirements set forth in the Medical Staff Bylaws and Rules and Regulations relative to privileges, either temporary privileges or privileges granted in connection with Medical Staff membership.

Section 15: General Rules Regarding Tissue Review

Tissue review consists of the evaluation of normal or possibly inappropriate tissues removed at surgery which is documented in the Pathology minutes of the Department of Laboratory and sent to the Performance Improvement staff for their submission to the appropriate Operating Department for their review and documentation.

Section 16 Allied Health Professionals

16.1 General Policies

Health care providers who are not members of the Medical Staff nor employees of the Medical Center but are necessary for the maintenance of a high standard of health care in the Medical Center may be granted the status of "Allied Health Professional" (AHP). Departmental Rules and Regulations will define the categories of AHPs, the application process, the scope of clinical, administrative, and educational activities, the standardized procedures if applicable, and the role of supervising physicians. If indicated, the Department will develop standardized procedures and will obtain approval of same.

I) AHPs are not members of the Medical Staff. Nothing in these Rules and Regulations shall be construed to provide the rights and privileges of Medical Staff membership to AHPs.

II) Persons granted AHP status may provide services in the Medical Center under the direction of physicians who are members of the Medical Staff. AHPs may perform those functions authorized by the appropriate professional board. Each AHP will be assigned to a Department of the Medical Staff.

III) The types of AHPs allowed to practice at the Medical Center will be ultimately determined by the Governing Body, based upon the recommendation of the Medical Executive Committee.

16.2 Independent Practitioners:

Certified Registered Nurse Anesthetists (CRNA), and Certified Nurse Midwives (CNM) may be granted clinical privileges.

I) The Department Chairman will provide to the Credentials Committee the information needed to support an application for clinical privileges including a written recommendation. The process of applying for such privileges and of ~~all~~ verifying the information provided shall be as described in the Medical Staff Bylaws, Article V. The Credentials Committee will recommend approval or disapproval of the application to the Executive Committee, which shall, in turn, make a recommendation to the Governing Body to take the final action.

II) Applications for renewal of clinical privileges will document current clinical competence based, at least in part, on the results of indicator based quality assessment activities.

III) The mechanisms for physician back up and provisions for on call coverage will be
described in the application materials.

IV) The Medical Staff Department in which the AHP will exercise clinical privileges has a role in establishing criteria for the exercise of specific clinical privileges in that department, and in evaluating whether the particular applicant meets the established criteria. The departments have the responsibility for generally supervising AHPs therein, through their proctoring and peer review mechanisms.

16.3 Dependent Practitioners:

Dependent Practitioners including but not limited to Nurse Practitioners, Physicians' Assistants, Clinical Psychologists provide direct care to patients as permitted by their license and the Bylaws and Rules and Regulations of the Medical Staff. A written job description approved by the Committee on Interdisciplinary Practice and Executive Committee outlines the scope of practice for each classification. These individuals are to be employees of a corporation or its contractors. The employer is responsible for verification of qualifications at the time of initial employment.

I) Verification of Competence

The Department Chairman or designee is responsible for verifying the competence of the individual provider within six months of employment and at least annually thereafter. Objective valid criteria and performance standards approved by the Committee on Interdisciplinary Practice and Executive Committee will be used. Competence is verified with respect to the organizational components which are standard for all groups, the classification specific requirements, and those which are specialty specific.

The Department to which the practitioner is assigned is responsible for validating competence. This may be done by a physician, by a supervisor or by a peer whose initial competence has been validated. Competence may be verified by direct observation and/or by verbal or written reports. Summary documentation of the assessment will be filed in the practitioner's Medical Staff Office file. This will include a plan to correct any deficiencies identified and a re-evaluation date. Back up documentation, as appropriate, will be maintained in the practitioner's assigned department.

An education file for each dependent practitioner will be maintained in the office of the Department to which the practitioner is assigned. A quarterly summary of the status of these reports will be provided to the CIDP and Executive Committee of the Medical Staff.

16.4 Supervising Physician(s) – Need for

The rights of an AHP to provide care is contingent upon availability of appropriate physician supervision. A physician member of the Medical Staff must be available and qualified to provide the appropriate level of supervision. Physicians supervising dependent or independent AHP's will ensure that the established physician to AHP ratio, if any, is not exceeded.

An AHP's clinical privileges shall automatically terminate in the event that the Medical Staff membership of the supervising physician is terminated, whether such termination is voluntary or involuntary, or if the supervising physician no longer agrees to act as the supervising practitioner for any reason, or if the relationship between the AHP and the supervising physician is otherwise terminated, regardless of the reason.

16.5 Disciplinary Action – Excluding CNM, CRNA, Psychologist

After consultation with the supervising physician(s) and the Department Chairman, an individual AHP's job duties with the exception of Certified Registered Nurse Anesthetist (CRNAs), Certified Nurse Midwives (CNMs) and Clinical Psychologists may be modified or terminated by the Executive Committee at any time. The Executive Committee shall promptly advise the Allied Health Professional, the supervising physician(s) and the Department Chairman in writing of any such suspension or restriction, and the grounds for such action.

I) Automatic Suspension or Restriction shall be immediately imposed if:

A) An AHP's certification, license or other legal credential expires, is revoke
or is restricted by the applicable board or agency. If the suspension is due to expiration of a license or other such credential, it will be lifted upon verification of renewal.

B) There are no hearing or appeal rights under these circumstances from the Medical Center's suspension or restriction of the AHP.

16.6 Responsibilities

I) Each AHP shall:

A) Meet those responsibilities required by the Medical Staff and or Departmental Rules and Regulations and if not so specified, meet those responsibilities specified in the Medical Staff Bylaws and Medical Center Policies and Procedures.

B) Retain appropriate responsibility within his or her area of professional competence for the care of each patient in the Medical Center for whom he or she is providing services.

C) Participate, when requested, in patient care audit and other quality review, evaluation and monitoring activities required of AHPs in evaluating AHP applicants, in supervising initial AHP appointees of his

or her same occupation or professional; discharging such other functions as may be required by the Medical Staff from time to time.

16.7 Termination of AHP's Status Due to Alteration of AHP's Contractual/Employment Status

If an AHP's employment/contractual status with a entity contracting directly or indirectly with the County of San Bernardino terminates or is terminated, the individual's status as an approved AHP and/or attendant clinical privileges shall likewise be terminated.

Section 17: Hearing Rights and Appeal for Certified Registered Nurse Anesthetists and Certified Nurse Midwives

17.1 Hearing Rights and Appeal

If the privileges of an Allied Health Professional in these classifications are suspended, restricted, or limited by the Executive Committee, the Department Chairman shall be entitled only to the procedural rights provided in this Section.

I) Hearing Rights For Restriction, Limitation or Modification or Termination of AHP's clinical privileges

The Department Chairman may, within five (5) working days after receipt of written notice from the Executive Committee of such action, request a hearing before the Executive Committee. The request shall be by written notice to the Medical Director. The hearing date shall be set not less than thirty (30) days nor more than sixty (60) days from receipt of the request by the Medical Director. Both the Department Chairman and the AHP shall be given at least five (5) working days notice of the time and place of the hearing. In the event the Department Chairman does not request a hearing within the time and in the manner specified above, the action involved shall be deemed to have been accepted.

II) Hearing Rights For Summary Suspension Or Termination Of Clinical Privileges

The Department Chairman, within five (5) working days of receipt of written notice of such action, may request a hearing before the Executive Committee. The request shall be by written notice to the Medical Director. The hearing date shall be set not less than fifteen (15) days from the date of receipt of the request by the Medical Director for hearing. Both the Department Chairman and the AHP shall be given at least five (5) working days notice of the time and place of the hearing. In the event the Department Chairman does not request a hearing within the time and in the manner specified above, the action involved shall be deemed to have been accepted.

III) Hearing Procedure

The hearing shall be conducted informally as a professional discussion without the participation of legal counsel or application of technical rules of evidence. The decision of the Executive Committee shall be final as to all substantive matters. Said decision shall be rendered within ten (10) working days after final adjournment of the interview (provided that in the event the member is currently under suspension or termination, this time shall be five [5] working days), and shall be in writing. Such decision and report shall be delivered to the Governing Body, and to the Department Chairman who requested the hearing.

IV) Appeal

The Department Chairman may appeal the Executive Committee's decision to the Governing Body only with respect to the fairness of the hearing. A written request to the Governing Body for such review shall be delivered to the Medical Director within five (5) days after receipt by the Department Chairman of the decision of the Executive Committee. The Governing Body may hear the appeal directly or it may, in its sole discretion, refer the matter to an individual designated as "Hearing Officer" for such proceedings as the Governing Body may direct. The Hearing Officer may not be legal counsel to the Medical Center and must not act as a prosecuting officer, an advocate for the Medical Center, Governing Body, or any other body whose action prompted the proceedings. The Hearing Officer shall be an attorney at law admitted to practice in the State for at least ten (10) years, and shall possess any additional qualifications determined by the Governing Body.

The appeal hearing shall be conducted within 30 days of the Governing Body's receipt of the request. A written decision, which shall be final, will be provided to the affected parties.

Section 18: Disaster Plan

18.1 There is a plan for the care of casualties during a major disaster, which is based on the Medical Center's capabilities, and that of facilities in the community. It is developed by a multidisciplinary sub-committee of the Safety Committee and has Medical Staff representation.

I) The plan addresses:

A) The availability of basic utilities and supplies;
B) An efficient system for notifying and assigning personnel;
C) Defined areas for triage, patient observation, and immediate care;
D) Procedures for the prompt discharge and transfer of hospital patients who can safely be moved;
E) Maintenance of security;
F) Establishment of a public information center and public relations liaison.
G) Specific assignments for employees, members of the Medical Staff and AHP's.

18.2 The Disaster Plan is rehearsed no less than twice a year, preferably as part of a coordinated drill with other community agencies. One drill is to include a partial evacuation of the Medical Center.

18.3 During an emergency, outside physicians or licensed AHPs may request emergency privileges or authorization to provide care. A current license and photo identification will be required before authorization is granted. If possible, verification that the practitioner is in good standing at another acute care facility will be obtained. A complete record of all such authorizations will be maintained with photocopies of the license and identification if feasible. The physician/AHP will work with a Arrowhead Regional Medical Center physician whose name should be recorded along with the licensing information.

Section 19: Operation of Medical Staff Office

As required, guidelines for the conduct of Medical Staff affairs or policies and procedures for the operation of the Medical Staff Office will be developed which are consistent with the Medical Staff Bylaws, Rules and Regulations and Committee

Manuals and policies of the Medical Center. These will be reviewed and approved by the applicable Medical Staff Committee and the Executive Committee of the Medical Staff. They will be updated no less than biennially. The Medical Staff Office will maintain a complete copy of all such guidelines, policies, and procedures.